PLAN OF CARE / COST COMPARISON BUDGET FOR THE TBI WAIVER

State Form 49413 (7-99) / HCBS 1E/2E
Approved by State Board of Accounts, 1999

Information contained in this record is **CONFIDENTIAL** pursuant to 42 CFR 431(f).

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CENTRAL OFFICE USE ONLY		
	Date	**Initials**
OMPP		
MWU		
Returned		

☐ Initial Plan of Care ☐ Update Plan of Care ☐ Annual Plan of Care
☐ Re-Entry - Previous Termination Date _____

Last name	First name	Middle initial	Area agency number	BDDS number

Address *(number and street, rural route or box number)*	City	State	ZIP code

Medicaid number	Medicaid eligibility date	Date of birth	Social Security number

Level of Care *(please check)* ☐ K ☐ L	Level of Care - current approval date (*month, day, year*)	Level of Care - previous approval date (*month, day, year*)

Diagnosis 1 *(from 450B)*	Diagnosis 2 *(from 450B)*	S.B. provision *(please check)* ☐ Yes ☐ No

Start Date Waiver Effective Date		**Medical Facility Discharge Date**	

Recommendation

Plan of Care Effective From To

A. HOME AND COMMUNITY-BASED CARE COSTS

1. Plan of Care Information

a. Case Management . . . . . (1/4 hr.) Units auth. / mo. _____ x Unit cost $ _____ = Mo. cost $ _____
b. Homemaker/HHA/HSA .. . . . . (1 hr.) Units auth. / mo. _____ x Unit cost $ _____ = Mo. cost $ _____
/Non Agency. . . . . (1 hr.) Units auth. / mo. _____ x Unit cost $ _____ = Mo. cost $ _____
c. Adult Companion/HHA-HSA . . . . . (1 hr.) Units auth. / mo. _____ x Unit cost $ _____ = Mo. cost $ _____
/ IDDARS-ILS . . . . . (1 hr.) Units auth. / mo. _____ x Unit cost $ _____ = Mo. cost $ _____
/Non Agency . . . . . (1 hr.) Units auth. / mo. _____ x Unit cost $ _____ = Mo. cost $ _____
d. Respite Care/Personal Care . . . . (1 hr.) Units auth. / mo. _____ x Unit cost $ _____ = Mo. cost $ _____
/Companion . . . . . (1 hr.) Units auth. / mo. _____ x Unit cost $ _____ = Mo. cost $ _____
/Homemaker. . . . . (1 hr.) Units auth. / mo. _____ x Unit cost $ _____ = Mo. cost $ _____
/Home Health Aide. . . . . (1 hr.) Units auth. / mo. _____ x Unit cost $ _____ = Mo. cost $ _____
/LPN . . . . . (1 hr.) Units auth. / mo. _____ x Unit cost $ _____ = Mo. cost $ _____
/RN . . . . . (1 hr.) Units auth. / mo. _____ x Unit cost $ _____ = Mo. cost $ _____
/IDDARS-ILS . . . . . (1/2 hr.) Units auth. / mo. _____ x Unit cost $ _____ = Mo. cost $ _____
/Other . . . . . (1 hr.) Units auth. / mo. _____ x Unit cost $ _____ = Mo. cost $ _____
e. Personal Care/HHA. . . . . (1 hr.) Units auth. / mo. _____ x Unit cost $ _____ = Mo. cost $ _____
f. Residential Care/Community Residential
/HHA/HSA . . . . . (1 hr.) Units auth. / mo. _____ x Unit cost $ _____ = Mo. cost $ _____
/IDDARS-ILS . . . . . (1/2 hr.) Units auth. / mo. _____ x Unit cost $ _____ = Mo. cost $ _____
/Non-Agency . . . . . (1 hr.) Units auth. / mo. _____ x Unit cost $ _____ = Mo. cost $ _____
g. Rehabilitation
Independent Living Skills . . . . . (1/4 hr.) Units auth. / mo. _____ x Unit cost $ _____ = Mo. cost $ _____
Behavior Programming/Counseling and Training (1/4 hr.) Units auth. / mo. _____ x Unit cost $ _____ = Mo. cost $ _____
Structured Day Program/Group . . . . . (1/4 hr.) Units auth. / mo. _____ x Unit cost $ _____ = Mo. cost $ _____
Structured Day Program - Individual . . . . . (1/4 hr.) Units auth. / mo. _____ x Unit cost $ _____ = Mo. cost $ _____
Pre Vocational . . . . . (1/4 hr.) Units auth. / mo. _____ x Unit cost $ _____ = Mo. cost $ _____
Supported Employment . . . . . (1/4 hr.) Units auth. / mo. _____ x Unit cost $ _____ = Mo. cost $ _____
h. Therapies
Speech/Language/Hearing. . . . . (1/4 hr.) Units auth. / mo. _____ x Unit cost $ _____ = Mo. cost $ _____
Occupational . . . . . (1/4 hr.) Units auth. / mo. _____ x Unit cost $ _____ = Mo. cost $ _____
Physical . . . . . (1/4 hr.) Units auth. / mo. _____ x Unit cost $ _____ = Mo. cost $ _____
i. Environmental Mod. *(describe)* _____ Unit cost $ _____ = Mo. cost $ _____
j. Personal Emergency Response System / Installation . . . . . Unit cost $ _____ = Mo. cost $ _____
/ Monthly Charge . . . . . = Mo. cost $ _____
k. Specialized Medical Equip/Supplies *(describe)* _____ Unit cost $ _____ = Mo. cost $ _____

TOTAL A.1 - Waiver Service Cost $ _____

TOTAL A.2 - Other Medicaid Cost $ _____

TOTAL A.5 - Total HCBS Cost $ _____

TOTAL B.7 - Facility Cost Factor $ _____

Case management agency	
Case manager I.D. number *(4 digits)*	Case manager authorization. number *(9 digits)*

Date budget completed *(mo., day, yr.)*

2. Other Medicaid Services

a. Physician . . . . . 3 mo. payment history $ _____ ÷ 3 = Estimate mo. cost $ _____

b. Pharmacy . . . . . 3 mo. payment history $ _____ ÷ 3 = Estimate mo. cost $ _____

c. Therapy . . . . . 3 mo. payment history $ _____ ÷ 3 = Estimate mo. cost $ _____

d. Lab / X-ray . . . . . 3 mo. payment history $ _____ ÷ 3 = Estimate mo. cost $ _____

e. Supplies . . . . . 3 mo. payment history $ _____ ÷ 3 = Estimate mo. cost $ _____

f. Durable medical Equipment . . . . . 3 mo. payment history $ _____ ÷ 3 = Estimate mo. cost $ _____

g. Transportation . . . . . 3 mo. payment history $ _____ ÷ 3 = Estimate mo. cost $ _____

h. Other _____. . . . . 3 mo. payment history $ _____ ÷ 3 = Estimate mo. cost $ _____

i. Other _____. . . . . 3 mo. payment history $ _____ ÷ 3 = Estimate mo. cost $ _____

j. Other _____. . . . . 3 mo. payment history $ _____ ÷ 3 = Estimate mo. cost $ _____

TOTAL A.2 - Other Medicaid Cost $ _____

3. Total of Lines A.1 $ _____ + A.2 $ _____ = $ _____ A.3

4. Minus Recipient Spend-down Amount - $ _____ A.4

5. Total Home and Community Care Costs = $ _____ A.5

B. NURSING FACILITY INSTITUTIONAL COSTS

1. NF per diem $ _____ x 30 days

= $ _____ B.1

2. Other Medicaid Services

a. Physician . . . . . 3 mo. payment history $ _____ ÷ 3 = Estimate mo. cost $ _____

b. Pharmacy . . . . . 3 mo. payment history $ _____ ÷ 3 = Estimate mo. cost $ _____

c. Lab / X-ray . . . . . 3 mo. payment history $ _____ ÷ 3 = Estimate mo. cost $ _____

d. Transportation . . . . . 3 mo. payment history $ _____ ÷ 3 = Estimate mo. cost $ _____

e. Other _____. . . . . 3 mo. payment history $ _____ ÷ 3 = Estimate mo. cost $ _____

f. Other _____. . . . . 3 mo. payment history $ _____ ÷ 3 = Estimate mo. cost $ _____

g. Other _____. . . . . 3 mo. payment history $ _____ ÷ 3 = Estimate mo. cost $ _____

TOTAL B.2 - Other Medicaid Cost $ _____

3. Total of Lines B.1 $ _____ + B.2 $ _____ = $ _____ B.3

4. Minus Recipient Liability Reduction - $ _____ B.4

5. Total Nursing Facility Costs = $ _____ B.5

C. DOCUMENTATION OF PAYMENT HISTORY *(indicate sources and dates of information used to determine cost report in Section A.2)*

D. NON-REIMBURSED CAREGIVER(S) *(i.e., family, friends)*

Type	Provider *(specify name and address)*	Telephone Number	Frequency
PRIMARY CAREGIVER	Name Address		

E. DESCRIPTION *(please describe how the Plan of Care provides adequate coverage to ensure the health and welfare of the waiver services recipient. For Update Plan of Care, explain reason for change.)*

F. COST COMPARISON DETERMINATION

1. Cost Comparison Data Indicates

a. If Line **A.5** $ _____ is **LESS THAN** line **B.7** $ _____, then the recipient is **ELIGIBLE** for Home and Community-Based Waiver Services and must be offered the choice of Nursing Facility Institutional Care or Home and Community-Based Services.

☐ Recipient is **ELIGIBLE** for Home and Community-Based Waiver Services.

b. If Line **A.5** $ _____ is **GREATER THAN** line **B.7** $ _____, then the recipient is **MAY NOT BE ELIGIBLE** for Home and Community-Based Waiver Services.

☐ Recipient **MAY NOT BE ELIGIBLE** for Home and Community-Based Waiver Services.

2. Request for Approval to Exceed Calculations

a. Monthly amount which exceeds institutional cost factor: $ _____

b. Duration of excess costs: _____

3. State Agency Determination to Exceed Cost

☐ Approved ☐ Denied

Authorized signature of waiver unit	Date signed *(month, day, year)*

G. FREEDOM OF CHOICE

A Medicaid Waiver Services case manager has explained the array of services available to meet my needs through the Medicaid Home and Community-Based Services Waiver. I have been fully informed of the services available to me in a Nursing Facility institutional setting. I understand the alternatives available and have been given the opportunity to choose between waiver services and institutional care. As long as I remain eligible for waiver services, I will continue to have the opportunity to choose between waiver services and institutional care.

1. Choice of Waiver Services

☐ At this time, I have chosen to receive waiver services in a home and community-based setting, rather than in an institutional setting.

Signature of recipient / guardian	Date signed *(month, day, year)*

2. Choice of Institutional Services

☐ At this time, I have chosen to receive services in an institutional setting, rather than in a home and community-based setting.

Signature of recipient / guardian	Date signed *(month, day, year)*

H. CHOICE OF PROVIDERS

If the recipient chooses to receive waiver services, they have the right to select any approved waiver service provider(s).

☐ I have been informed of my right to choose any certified waiver service provider when selecting waiver service providers.

Signature of recipient / guardian	Date signed *(month, day, year)*

I. EMERGENCY BACKUP PLANS

Describe how medical needs, supervision, behavior issues, etc., will be covered during an emergency.

J. NOTES *(including documentation of unmet needs)*

K. SIGNATURES

Signature of Case Manager	Case Manager I.D. number	Date signed *(month, day, year)*

L. STATE AGENCY PLAN OF CARE DETERMINATION

"INITIAL" and "RE-ENTRY" **ONLY**

☐ Approved ☐ Disapproved

Signature of Authorized Waiver Representative	Date signed *(month, day, year)*